SAINT FRANCIS
Hospital and Medical Center

R. Christopher Hartley
Senior Vice President
Planning and Facility Development

114 Woodland Street
Hartford, Connecticut
06105-1299

860 714-5573
Fax 860 714-8093

October 14, 2004

Cristine A. Vogel, MPH
Commissioner
Office of Health Care Access
410 Capitol Avenue
MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Commissioner;

Enclosed is a Letter of Intent/Waiver for Saint Francis Hospital and Medical Center's request to transfer all existing Manchester Teamworks clients from the Manchester site to other behavioral health providers. If approved by Office of Health Care Access Saint Francis Hospital and Medical Center would close the Manchester Teamworks site.

We appreciate your consideration in this matter. If you have any questions or need additional information please call me at 714-5573.

Sincerely,

Chris Hartley
Senior Vice President
Planning and Facilities Development

enclosure

State of Connecticut
Office of Health Care Access
Letter of Intent/ Waiver Form (2030)

All applicants must complete a Letter of Intent (LOI) form prior to submitting a Certificate of Need application, pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes and Section 19a-160-64a of OHCA's Regulations. Applicants should submit this form to the Commissioner of the Office of Health Care Access, 410 Capitol Avenue, MS# 13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. APPLICANT INFORMATION

If more than two Applicants, please attach a separate sheet of paper and provide additional information in the format below.

	Applicant One	Applicant Two
Full legal name	**Saint Francis Hospital and Medical Center**	
DBA (Doing Business As)	**Saint Francis Hospital and Medical Center**	
Name of Parent Corporation	**Saint Francis Hospital and Medical Center**	
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail	**114 Woodland Street Hartford,CT 06105-1299**	
Applicant type (e.g., profit/ non-profit)	**Non-Profit**	
Contact person, including title or position	**Chris Hartley Senior Vice President Planning and Facilities Development**	
Contact person's street mailing address	**Saint Francis Hospital and Medical Center Planning Office 114 woodland Street Hartford, CT 06105-1299**	
Contact person's phone #, fax # and e-mail address	**860-714-5573 phone 860-714-8093 fax Chartley@stfranciscare.org**	

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title: **Transfer Ownership of the Manchester Teamworks Program from Saint Francis Hospital and Medical Center to Other Behavioral Health Providers**

b. Type of Proposal, please check all that apply:

☐ Change in Facility (F), Service (S) or Function (Fnc) pursuant to Section 19a-638, C.G.S.

☐ New (F, S, Fnc)	☐ Replacement	☐ Additional (F, S, Fnc)
☐ Expansion (F, S, Fnc)	☐ Relocation	☐ Service Termination
☐ Bed Addition	☐ Bed Reduction	☒ Change in Ownership or Control

☐ Capital Expenditure pursuant to Section 19a-639, C.G.S.

- ☐ Project cost greater than $ 1,000,000
- ☐ Equipment Acquisition greater than $ 400,000

☐ New	☐ Replacement	☐ Major Medical
☐ Imaging	☐ Linear Accelerator	

- ☐ Change in ownership or control, pursuant to Section 19a-639 C.G.S., resulting in a capital expenditure over $1,000,000

c. Location of proposal (Town including street address): **Saint Francis Hospital and Medical Center114 Woodland Street, Hartford, CT 06105-1299**

d. List all the municipalities this project is intended to serve: **The town of Manchester, CT and surrounding towns.**

e. Estimated starting date for the project: **Saint Francis Hospital and Medical Center can transfer ownership by May 1, 2005.**

f. Type of project: ___**18**_____ **(Fill in the appropriate number(s) from page 4 of this form)**

Number of Beds (to be completed if changes are proposed)

Type	Existing Staffed	Existing Licensed	Proposed Increase (Decrease)	Proposed Total Licensed
N/A	**N/A**	**N/A**	**N/A**	**N/A**
N/A	**N/A**	**N/A**	**N/A**	**N/A**

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Capital Expenditure: **$0**

b. Please provide the following breakdown as appropriate:

Construction/ Renovations	**$0**
Medical Equipment (Purchase)	**$0**
Imaging Equipment (Purchase)	**$0**
Non Medical Equipment (Purchase)	**$0**
Sales Tax	**$0**
Delivery and Installation	**$0**
Total Capital Expenditure	**$0**
Fair Market Value of Leased Equipment	**$0**
Total Capital Cost	**$0**

Major Medical equipment acquisition:

Equipment Type	Name	Model	Number of Units	Cost per Unit
N/A	**N/A**	**N/A**	**N/A**	**N/A**

Note: Provide a copy of the contract with the vendor for major medical imaging equipment

c. Type of financing or funding source (more than one can be checked):

☐ Applicant's Equity ☐ Lease Financing ☐ Conventional Loan
☐ Charitable Contributions ☐ CHEFA ☐ Grant Funding
☐ Other (specify): _____ ☐ Funded Depreciation

This question is not applicable since there are no proposed capital costs.

SECTION IV. PROJECT DESCRIPTION

Please attach a separate 8.5" X 11" sheet(s) of paper and provide no more than a 2 page description of the proposed project, highlighting all the important aspects of the proposed project. Please be sure to address the following (if applicable):

1. Currently what types of services are being provided? If applicable, provide a copy of each Department of Public Health license held by the Petitioner.
2. What types of services are being proposed and what DPH licensure categories will be sought, if applicable?
3. Who is the current population served and who is the target population to be served?
4. Identify any unmet need and how this project will fulfill that need.
5. Are there any similar existing service providers in the proposed geographic area?
6. What is the effect of this project on the health care delivery system in the State of Connecticut?
7. Who will be responsible for providing the service?
8. Who is are the payers of this service?

See the attached summary.

If requesting a Waiver of a Certificate of Need, please complete Section V.

SECTION V. WAIVER OF CON FOR REPLACEMENT EQUIPMENT

I may be eligible for a waiver from the Certificate of Need process because of the following: (Please check all that apply)

☐ This request is for Replacement Equipment
- ☐ The original equipment was authorized by the Commission/OHCA in Docket Number:
- ☐ The cost of the equipment is not to exceed $2,000,000
- ☐ The cost of the replacement equipment does not exceed the original cost increased by 10% per year.

Please complete the attached affidavit for Section V only.

This question is not applicable since Saint Francis Hospital and Medical Center is not proposing to replace any equipment in this letter of intent.

Project Type Listing

Please indicate the number or numbers of types of projects that apply to your request on the line provided on the Letter of Intent Form (Section II, page 2).

Inpatient

1. Cardiac Services
2. Hospice
3. Maternity
4. Med/ Surg.
5. Pediatrics
6. Rehabilitation Services
7. Transplantation Programs
8. Trauma Centers
9. Behavioral Health (Psychiatric and Substance Abuse Services)
10. Other Inpatient

Outpatient

11. Ambulatory Surgery Center
12. Birthing Centers
13. Oncology Services
14. Outpatient Rehabilitation Services
15. Paramedics Services
16. Primary Care Clinics
17. Urgent Car Units
18. Behavioral Health (Psychiatric and Substance Abuse Services)
19. MRI
20. CT Scanner
21. PET Scanner
22. Other Imaging Services
23. Lithotripsy
24. Mobile Services
25. Other Outpatient
26. Central Services Facility

Non-Clinical

27. Facility Development
28. Non-Medical Equipment
29. Land and Building Acquisitions
30. Organizational Structure (Mergers, Acquisitions, Affiliations, and Changes in Ownership)
31. Renovations
32. Other Non-Clinical

Summary

On March 25, 2004, in the Certificate of Need under DN:03-30166 Blue Ridge Health Services, Inc./Saint Francis Hospital and Medical Center, Hartford Hospital, Natchaug Hospital, and Rushford Center received authorization to transfer all of Blue Ridge Health Services, Inc./Saint Francis Hospital and Medical Center's outpatient Behavioral Health Programs with the exception of the Teamworks program in Manchester, CT to other existing Behavioral Health providers.

The Manchester Teamworks program located on 63 East Center Street in Manchester, CT treats adults, adolescents and children with psychiatric, substance abuse and dual-diagnosis disorders in partial hospital and outpatient settings. Currently there are 5, 11 and 9 clients enrolled in the child, adolescent and adult programs respectively.

Since March 2004 Saint Francis Hospital and Medical Center has been working with a group of stakeholders in children's behavioral health care services. This group of stakeholders included local social service agencies, state and local elected officials, area hospitals and other interested parties. The purpose of these meetings was to develop a community solution that would allow transfer of Manchester Teamwork clients to other interested providers. In addition, every effort would be made to preserve access to behavioral health care services for children under 12 in the town of Manchester.

As a result of these meetings, Saint Francis Hospital and Medical Center in concert with Community Child Guidance Clinic, Manchester, Manchester Hospital and Natchaug Hospital has developed a proposal that would transfer all existing Manchester Teamworks clients from the Manchester Teamworks Program to the following providers: a.) children under 12 years old would be transferred to the Community Child Guidance Clinic, Manchester b.) adolescents would be transferred to other area adolescent behavioral health providers with a focus on Manchester Hospital for Manchester area residents, c.) adults would be transferred to Natchaug Hospital's adult behavioral health program located in Vernon, CT or Manchester Hospital's adult behavioral health program located in Manchester, CT. Once Saint Francis Hospital and Medical Center receives authorization to transfer its Manchester Teamworks clients, it intends to close the program.

Saint Francis Hospital and Medical Center believes these proposed changes are necessary to provide the most efficient behavioral health care services for clients in the Manchester area. Saint Francis Hospital and Medical Center also believes the proposed solution will allow all Manchester Teamworks clients to be served by other area behavioral health providers with minimal disruption in services.

There will be no capital costs associated with these transfers nor will there be any negative impact on the reimbursement system for behavioral health care services as a result of this proposal.

AFFIDAVIT

Applicant: **Saint Francis Hospital and Medical Center**

Project Title: **Transfer Ownership of the Manchester Teamworks Program from Saint Francis Hospital and Medical Center to Other Behavioral Health Providers.**

I, **Christopher Dadlez, President and Chief Executive Officer**
(Name) (Position – CEO or CFO)

of **Saint Francis Hospital and Medical Center** being duly sworn, depose and state that the information provided in this CON Letter of Intent/Waiver Form (2030) is true and accurate to the best of my knowledge, and that **Saint Francis Hospital and Medical Center** complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature 10/12/04
Date

Subscribed and sworn to before me on October 12, 2004

Martha E. Hartle
Notary Public/Commissioner of Superior Court

My commission expires: MARTHA E. HARTLE NOTARY PUBLIC MY COMMISSION EXPIRES MAY 31, 2009